5/30

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC#2	445409	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NASHVILLE METRO CARE AND REHABILITATION CENTER	2030 25TH AVE N NASHVILLE, TN 37208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Fed Report Stories: 2 with partial basement Construction Type: II (000) per construction drawings Constructed: 1965 Sprinkled: Yes Census: 71 Certified beds: 111 PoC Accepted 5/12/2017 A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 4/19/2017 following a survey by the Middle Tennessee Regional Office of Health Care Facilities state survey agency on 3/27/2017. At this Comparative Federal Monitoring Survey, Nashville Metro Care and Rehabilitation Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 43 483.70(a) and 483.70(b), Life Safety from Fire, and the related National Fire Protection Association (NFPA) publications, the 2012 edition of NFPA 101 Life Safety Code and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3 and TIA 12-4 and the 2012 edition of NFPA 99 Health Care Facilities Code and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6.	K 000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.	
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system	K 321 SS=E	1. CORRECTIVE ACTIONS TAKEN: a. By 05/07/2017 the Environmental Supervisor will install door hardware so the doors to the Housekeeping Storage Room, Central Supply Storage Room, and the Maintenance Repair shop are self-closing or close automatically to meet set standards. The Administrator will verify the repairs by 05/20/2017. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were.	05/21/2017 05/21/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Tammy Harrison | CEO | 5.5.2017

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 321	Continued From page 1 option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (If classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to protect hazardous areas per the requirements of: 2012 NFPA 101 Section 19.3.2.1.3 The deficiency affected three rooms in the basement. Findings include: On 4/19/2017from 2:15 p.m. to 2:45 p.m., the doors to the housekeeping storage room, central supply storage room and the maintenance repair shop were not self-closing or automatic closing.	K 321 SS=E	Continued From page 1 By 05/20/2017 the Environmental Supervisor will inspect doors to all hazardous areas throughout the facility to ensure they self-close or close automatically and found no other negative findings. 3. MEASURES TO PREVENT REOCCURRENCE: a. Environmental Supervisor/designee will inspect doors to all hazardous areas throughout the facility monthly to insure they self-close or close automatically as a part of the facility's Monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Environmental Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION a. The inspection results will be presented by the Environmental Supervisor/designee to the Administrator weekly and at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting.	05/21/2017 05/21/2017

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K 321	Continued From page 2 The Maintenance Director was present when the deficiencies were identified	K 321 SS=E	Continued From page 2 Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 05/20/2017.	05/21/2017
K 361 SS=D	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to separate areas from the corridor per the requirements of: 2012 NFPA 101 Section 19.3.6.1 (1) or (7) On 4/19/2017 at 12:30p.m., the door was removed from the 1st floor copy room. An electronically supervised automatic smoke detection system was not installed in the copy room and the room was not located to allow direct supervision from a nurse station. The Maintenance Director was present when the deficiency was identified.	K 361 SS=D	1. CORRECTIVE ACTIONS TAKEN: a. By 05/20/2017 a licensed fire sprinkler contractor installed a smoke detector in the 1st Floor Copy Room to protect the room to meet set standards. The Administrator will verify the repairs by 05/20/2017.	05/21/2017
			2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were. By 05/20/2017 the Environmental Supervisor checked all other areas open to the corridors throughout the facility and found no other negative findings.	05/21/2017
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke		3. MEASURES TO PREVENT REOCCURRENCE: a. Environmental Supervisor/designee will check all areas open to the corridors throughout	05/21/2017

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K 363	Continued From page 3 compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the latches of doors protecting corridor openings per the requirements of: 2012 NFPA 101 Section 19.3.6.3.5 CFR 483.470(a)(1)(ii) The deficient practice affects 1 resident room. Findings include:	K 361 SS=D	Continued From page 3 the facility to insure they remain separated from the corridors monthly as a part of the facility's Monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Environmental Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Environmental Supervisor/designee to the Administrator weekly and at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 05/20/2017.	05/21/2017 05/21/2017

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K 363	Continued From page 4 On 4/19/2017 at 11:45 a.m., the door to resident room 205 did not latch when closed. The Maintenance Director was present when the deficiency was identified.	K 363 SS=D	Continued From page 4 1. CORRECTIVE ACTIONS TAKEN: a. On 04/19/2017 the Environmental Supervisor repaired the latch on the door to Resident Room #205 to latch completely when closed to meet set standards. The Administrator verified the repairs on 04/19/2017.	5/21/2017
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke and ½ hour fire resistance of smoke barriers per the requirements of: 2012 NFPA 101 Sections 19.3.7.3, 8.5, 8.5.6.3, 8.3.5.2 2012 NFPA 101 Sections 19.1.1.1.3, 19.1.1.2, 19.1.1.3.2, 4.1.1, 4.2.3, 4.5.8, 4.6.12.1, 4.6.12.2, 4.6.12.4 2012 NFPA 101 Sections 19.5.1, 9.1.2 2011 NFPA 70 Article 300-21, 760-3(a) The deficiency affected one of two smoke barriers.		2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were. On 04/19/2017 the Environmental Supervisor inspected all other resident room doors throughout the facility to ensure they latch completely when closed and found no other negative findings. 3. MEASURES TO PREVENT REOCCURRENCE: a. Environmental Supervisor/designee will inspect all other resident room doors throughout the facility monthly to ensure they latch completely when closed as a part of the facility's Monthly Preventive Maintenance Program and document those Inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Environmental Supervisor/designee will review with the Administrator the inspection results.	05/21/2017 05/21/2017

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K 372	Continued From page 5 Findings include: On 4/19/2017 at 1:00 p.m., the 1st floor smoke barrier wall was penetrated by a metal sleeve containing two red wires, the interior of the sleeve was not fire stopped. The Maintenance Director was present when the deficiency was identified.	K 363 SS=D	Continued From page 5 b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Environmental Supervisor/designee to the Administrator weekly and at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 05/20/2017.	05/21/2017
		K 372 SS=D	1. CORRECTIVE ACTIONS TAKEN: a. On 04/21/2017 the Environmental Supervisor used a fire-rated material to seal the penetration in the interior of the metal sleeve containing two (2) red wires in the 1st floor smoke barrier wall to meet set standards. The Administrator will verify the repairs by 05/20/2017.	05/21/2017

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		K 372 SS=D	Continued From page 6	
			2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were. By 05/20/2017 the Environmental Supervisor will inspect all smoke barriers throughout the facility for penetrations and found no other negative findings.	05/21/2017
			3. MEASURES TO PREVENT REOCCURRENCE: a. Environmental Supervisor/designee will inspect all smoke barriers throughout the facility monthly for penetrations as a part of the facility's Monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Environmental Supervisor/designee will review with the Administrator the inspection results.	05/21/2017
			b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	05/21/2017
			4. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Environmental Supervisor/designee to the Administrator weekly and at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to insure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 05/20/2017.	05/21/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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[signature]	CEO	5.5.2017